Reproductive Health Services in Rural Washington State: Scope of Practice and Provision of Medical Abortions, 1996–1997

Sharon A. Dobie, MCP, MD, Roger A. Rosenblatt, MD, MPH, Ann Glusker, PhC, David Madigan, PhD, and L. Gary Hart, PhD

A B S T R A C T

Objectives. This study explored reproductive health care in rural Washington State, reasons given by providers for not offering abortions, and providers' willingness to use medical abortifacients.

Methods. Physicians, midwives, nurse practitioners, and physician assistants in rural Washington completed an inventory of reproductive health services that they provide, whether and why they do not perform abortions, and whether they would use medical abortifacients.

Results. Of the respondents, 89.2% reported providing reproductive health care. Only 1.2% reported performing surgical abortions, and 26.1% indicated that they would probably prescribe medical abortifacients.

Conclusions. Few providers offer surgical abortions in rural Washington. Greater numbers report a willingness to prescribe medical abortifacients. (*Am J Public Health*. 2000;90:624–626)

As of 1994, 85% of women living in nonmetropolitan areas resided in the 94% of rural counties without an abortion provider.[1,2] Moral objections and community opposition are common reasons rural physicians report for not performing abortions.[3–6] Less is known about practices of physician assistants and nurse practitioners.[7,8] While it has been shown that one quarter of family physicians and obstetrician-gynecologists might use medical abortifacients when they are more readily available,[6,9] other providers of these medications have not been surveyed.

We surveyed all providers of reproductive health care in rural Washington State to ascertain the services they offered. We included nonphysician clinicians because in Washington State, nurse practitioners and physician assistants have broad prescriptive authority.

Methods

In April 1996, we identified all licensed rural Washington State providers in specialties providing reproductive health care to women, including MD and DO physicians in obstetrics–gynecology, family practice, pediatrics, internal medicine, and general surgery; certified and licensed nurse midwives; physician assistants; and nurse practitioners. All had addresses in counties characterized as nonmetropolitan by the US Office of Management and Budget.[10]

Provider lists were compiled from several professional and Washington State licensing databases (Washington State Department of Health, American Medical Association, DoctorLink, American Board of Medical Specialties).[11] We identified 685 rural physicians in relevant specialties. There were an additional 160 with unknown specialties and/or addresses.

Specialty information was not available for nonphysician clinicians before the survey was mailed. We excluded nonphysician clinicians who identified a specialty that did not involve women's reproductive health.

Questionnaires were mailed to 1135 providers. Of 917 responses, 210 were excluded because of urban or inapplicable addresses, inapplicable specialties, retirement, or death. We asked about demographics, practice characteristics, reproductive health services provided, whether the respondent performed abortions, reasons for not performing abortions, and whether the respondent would prescribe oral abortifacients.[6,12]

Analyses were conducted on 707 responses. Two-tailed χ^2 and exact tests were used to assess differences in response rate and to compare differences among subgroups of the sample. Unless otherwise stated, significance levels are reported as at least $P \leq .05$. Specialty sample sizes ranged from 8 providers to 275 providers, with confidence intervals varying accordingly. Regression analyses were used to explore correlates of providers' willingness to perform surgical abortions and use medical abortifacients.

Results

Our response rate was 76.3%. The difference in response rates across provider specialties was significant at $P = .04$ (Table 1).

Of the respondents, 67.5% were physicians, 2.1% were certified nurse midwives, 14.9% were nurse practitioners, 14.4% were physician assistants, and 1.1% were licensed midwives. Their mean age was 46.3 years. On average, they had practiced 14.4 years (Table 1).

The majority of providers (89.2%) reported offering reproductive care, with 31.5% of rural general surgeons providing this care. Most providers offered Papanicolaou test services (89.0%) and basic family planning services (oral contraceptives, diaphragms, and Depo-Provera; 58.9%). Almost half (47.4%) offered emergency contraception.

Sharon A. Dobie, Roger A. Rosenblatt, Ann Glusker, and L. Gary Hart are with the Department of Family Medicine, and David Madigan is with the Department of Statistics, University of Washington, Seattle.

Requests for reprints should be sent to Sharon A. Dobie, MCP, MD, University of Washington, Department of Family Medicine, Box 356390, Seattle, WA 98195-6390 (e-mail: dob@u.washington.edu).

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TABLE 1—Practice Characteristics of Rural Washington Providers of Reproductive Health Services, by Provider Type: 1996–1997

	Family Physicians (FPs)	Obstetrician-Gynecologists (Ob-Gyns)	Internists	Pediatricians	General Surgeons	Total MDs/ Doctors of Osteopathy (DOs)	Licensed Midwives	Certified Nurse Midwives (CNMs)	Nurse Practitioners (NPs)	Physician Assistants (PAs)	Total Nonphysician Clinicians	Total
No. of respondents[a]	275	35	77	51	39	477	8	15	105	102	230	707
Response rate[b]	76.4	76.1	76.2	89.5	76.5	77.6	53.3	. . .[c]	70.6[c]	81.0	74.0	76.3
Mean age, y	46.8	46.7	46.0	45.0	49.3	46.7	42.0	43.5	46.9	44.8	45.6	46.3
Female, %[d]	20.7	11.4	14.3	37.3	5.1	19.5	75.0	100.0	92.4	38.2	68.3	35.4
No. of ambulatory encounters per week, mean	95.0	81.2	84.3	97.3	39.1	88.5	16.8	36.9	55.3	92.3	69.4	82.2
(95% confidence interval)	(90.0, 100.3)	(71.1, 91.4)	(77.1, 91.5)	(87.0, 107.6)	(32.7, 45.4)	(84.6, 92.3)	(6.8, 26.7)	(26.5, 47.3)	(48.1, 62.5)	(84.0, 100.6)	(63.6, 75.1)	(78.9, 85.5)
Scope of ambulatory reproductive care, % providing[d]												
Some reproductive health care	96.3	100.0	87.5	77.6	31.5	87.9	100.0	100.0	94.1	88.2	92.1	89.2
>33% reproductive health	10.7	100.0	1.4	0.0	2.6	13.8	87.5	100.0	49.0	14.7	38.3	21.8
Papanicolaou tests	95.6	97.1	95.9	64.0	38.9	88.0	87.5	100.0	94.1	86.9	91.1	89.0
Basic family planning[e]	82.1	100.0	13.7	6.0	5.6	41.4	14.3	93.3	69.2	47.5	40.5	58.9
Emergency contraception	56.9	88.2	11.0	24.0	2.8	44.3	14.3	86.7	64.4	40.6	53.7	47.4
Scope of procedural reproductive care, % providing[d]												
First-trimester abortion	1.5	8.8	0.0	0.0	0.0	1.5	0.0	0.0	1.0	0.0	0.4	1.2
Amniocentesis	13.9	84.8	0.0	0.0	0.0	14.2	0.0	0.0	0.0	0.0	0.0	9.6
Obstetrics	50.2	97.1	0.0	2.0	0.0	36.9	87.5	80.0	2.0	5.9	12.1	28.8
Colposcopy	35.3	97.1	0.0	2.0	8.3	28.6	0.0	13.3	13.6	9.1	11.1	22.9
Dilatation and curettage	48.5	97.1	0.0	0.0	25.0	37.4	0.0	0.0	1.0	1.0	0.9	25.5
Vasectomy	52.4	8.8	2.7	0.0	58.3	36.2	. . .	. . .	. . .	. . .	. . .	36.2
Tubal ligation	29.5	100.0	0.0	0.0	30.6	26.9	. . .	. . .	. . .	. . .	. . .	26.9
Willing to prescribe oral abortifacients, %[f]	29.6	17.6	12.3	10.2	0.0	21.8	20.0	40.0	41.0	28.3	35.2	26.1

[a]The number of total respondents to the 15 questions varied from 677 to 707. Calculations are based on the number of responses to each question.
[b]χ^2 test for interspecialty differences in response rates significant at $P = .044$.
[c]Separate response rates could not be calculated for NPs and CNMs. CNMs are licensed as NPs, and we did not know the specialty of nonrespondents. The reported rate is a combined NP/CNM rate.
[d]For proportions, the confidence intervals by specialty are as follows: FPs, ±6.0%; Ob-Gyns, ±16.9%; internists, ±11.4%; pediatricians, ±14%; general surgeons, ±16%; MD/DOs, ±4.6%; licensed midwives, ±35.3%; CNMs, ±25.8%; NPs, ±9.8%; PAs, ±9.9%; nonphysician clinicians, ±6.6%; total, ±3.8%.
[e]Diaphragm, Depo-Provera, oral contraceptive medication.
[f]χ^2 test for interspecialty differences in response rates significant at $P < .0001$.

Of the 707 providers, only 8 (1.2%) reported performing first-trimester pregnancy terminations. These 8 providers (5 men and 3 women, practicing in 7 of Washington State's 28 rural counties) had a mean age of 47.7 years, had been in practice an average of 19.4 years (range: 11–32 years), and devoted 60.6% of their practice to women's reproductive health care. Seven were family physicians or obstetrician-gynecologists.

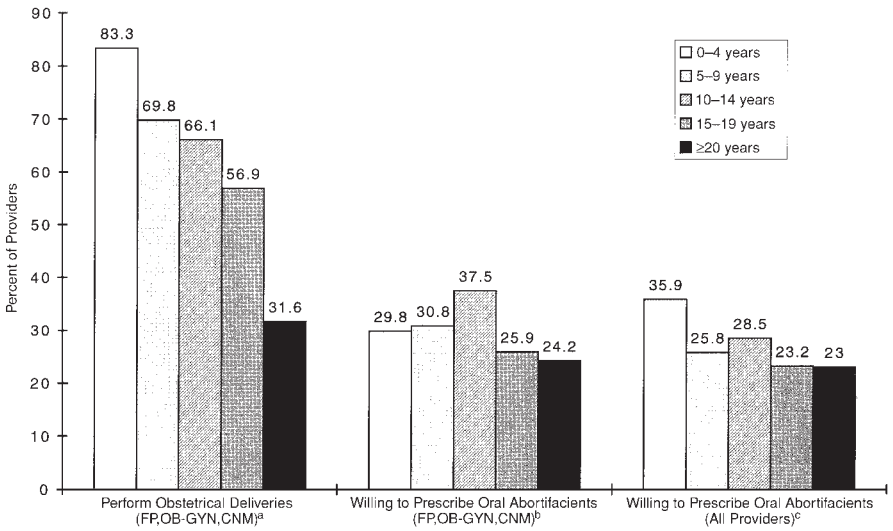
Of the family practice and obstetrician-gynecologist physicians who reported that they did not perform abortions, the majority cited community opposition (69.1%), personal moral objection (66.5%), and availability of the procedure at a reasonable distance (58.3%) as important reasons. Other reasons cited did not differ among family physicians and obstetrician-gynecologists with and without moral objections. Providers in other specialties were more likely than family physicians and obstetrician-gynecologists to name the threat of malpractice suits ($P = .005$), local availability of abortion services ($P = .002$), and lack of training ($P < .001$) as important.

Few of the respondents (1.9%) reported prescribing methotrexate and misoprostol to terminate pregnancies; 26.1% indicated that they would or probably would provide medical abortifacients when they became more common. There were no significant differences across specialties or sex in willingness to prescribe medical abortifacients. Number of years in practice was significantly associated with a decline in the proportion of obstetric providers practicing obstetrics ($P < .001$) but not with differences in their willingness to use medical abortifacients in practice ($P = .08$) (Figure 1).

Of those who reported that they would probably prescribe medical abortifacients and who gave reasons why, 44.7% cited a woman's choice and 15.4% indicated that medical abortifacients are safe, effective, or private. Another 30.9% reported that they would need information, training, or backup. Of the 459 respondents who reported that they would not prescribe medical abortifacients, 44.5% cited moral objections and 19.7% cited inadequate training, information, or support.

Discussion

Although reproductive health care is widely available in rural Washington State, few rural providers in the state are performing surgical or medical abortions. The primary reasons cited for not performing surgical abortions are similar across specialties and are consistent with those cited in other



Note. FP = family physicians; OB-GYN = obstetrician-gynecologists; CNM = certified nurse midwives.
[a]Significant across years of practice, $P<.001$.
[b]Not significant across years of practice, $P=.08$.
[c]Significant across years of practice, $P=.019$.

FIGURE 1—Obstetric providers' willingness to prescribe oral abortifacients, by number of years in practice: Washington State, 1996–1997.

states: community opposition and personal moral objections.[6] More than a quarter of the physician and nonphysician clinicians, however, were interested in providing medical abortions, although 30.9% cited a need for more information and training.

This study has several limitations. Although our response rate was high, we cannot comment on the bias introduced by nonresponse. Self-report of scope of practice is limited by the interpretation of the provider. Also, this study involved only one state. We do not know whether our descriptions of nonphysician clinicians' willingness to prescribe medical abortifacients are generalizable to other states with different licensing statutes.

The clear interest in this area demonstrated by nurse practitioners and physician assistants has not been studied before and identifies many providers who potentially can increase the local availability of pregnancy termination for rural women. Despite the current availability of oral abortifacients, very few providers are using them, and almost a third of willing providers noted a lack of training and support. Further research is needed to monitor changes in training, support, and use of medical abortifacients. It remains to be seen whether there will be an increase in local availability of pregnancy termination for rural women. □

Contributors

S. A. Dobie designed and planned the study, supervised data collection and analysis, and wrote the paper. R. A. Rosenblatt and S. A. Dobie designed and modified the study instrument. R. A. Rosenblatt, D. Madigan, and L. G. Hart contributed to the design of the study and the analysis of the results. A. Glusker performed the data analysis. R. A. Rosenblatt, A. Glusker, D. Madigan, and L. G. Hart all contributed to the writing of the paper.

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